REFUSAL OF TREATMENT

TODAY'S DATE: _____

EMPLOYEE NAME: _____

As of the date noted above I am notifying my employer of an injury that occurred on

(DATE OF INJURY): _____

☐ My supervisor did not receive notification of this incident.

☐ My supervisor did receive notification of this incident on (DATE): _____

This injury, (briefly describe condition)_____

_____

did occur during my normal scope and

At this time I have been requested by my employer to be medically evaluated by a *preferred medical provider.*However, ***I decline to be medically evaluated for the above noted condition.***

I understand that by signing this document any future claims regarding this injury will require a medical evaluation by the preferred healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must first notify my supervisor and go to the following provider:

PROVIDER:_____

ADDRESS:_____

PHONE:_____

SHOULD THE CONDITION BECOME LIFE THREATENING YOU SHOULD SEEK APPROPRIATE EMERGENCY MEDICAL CARE.

EMPLOYEE

By signing this form I acknowledge:

- I have not sought medical treatment for this injury.
- ***I understand that if it is the policy of my employer to have a post-accident drug screen this refusal of medical treatment does not remove the requirement that I receive a post-accident drug screen.***

I have read the above information and agree it is factual and a true statement. I authorize any physician, hospital, or healthcare provider to release and furnish any, and all, medical records or other information pertaining to the above listed condition.

Employee Signature:		**Date:**	
Supervisor/Witness Signature:		**Date:**	